Report

of the

Examination of

UnitedHealthcare of Wisconsin, Inc.

Wauwatosa, Wisconsin

As of December 31, 2003

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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October 14, 2004

Honorable Jorge Gomez
Commissioner of Insurance
Madison, Wisconsin

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

UNITEDHEALTHCARE OF WISCONSIN, INC.
Wauwatosa, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of UnitedHealthcare of Wisconsin, Inc., (UHCW or the HMO) was conducted in 2001 as of December 31, 2000. The current examination covered the intervening period ending December 31, 2003, and included a review of such 2004 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the company's operations, and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the Company
Reinsurance
Financial Statements
Accounts and Records
Data Processing

Emphasis was placed on the audit of those areas of the company's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the company to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results" contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the company's operations is contained in the examination work papers.

The company is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

UnitedHealthcare of Wisconsin, Inc., can be described as a for-profit, network model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as ". . . a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the network model, the HMO provides care through contracts with clinics and otherwise independent physicians operating out of their separate offices. HMOs compete with traditional fee-for-service health care delivery.

The HMO was incorporated on May 8, 1986, and commenced business on June 6, 1986, as the Heritage Health Plan of Wisconsin, Inc. Simultaneously, the HMO acquired all of the assets, and assumed all of the liabilities of the PrimeCare Health Plan of Wisconsin, pursuant to an Asset Purchase Agreement dated May 8, 1986. By shareholder consent dated May 11, 1987, the name of the HMO was changed to PrimeCare Health Plan, Inc. On March 1, 1990, United Health Care Corporation (United), a Minnesota managed care holding company, acquired Heritage Holding Company, Inc., (HHC) through purchase of all outstanding shares of common stock on March 1, 1990. HHC, which owned 100% of the HMO’s outstanding common stock at the time of the purchase, was subsequently dissolved, and the ownership interest in the HMO was transferred to UHC Management Company (UMC) (UMC is a wholly owned subsidiary of United). UMC subsequently changed its name to United HealthCare Services (UHS). On August 1, 1991, the HMO merged with an affiliate, Samaritan (which was also a wholly owned subsidiary of UMC). Samaritan, which was the surviving corporation, changed its name to PrimeCare Health Plan, Inc., pursuant to the merger. On July 17, 1996, the HMO merged with an affiliate, MetraHealth Care Plan of Wisconsin, Inc. The HMO (PrimeCare Health Plan, Inc.) was the surviving corporation. On June 30, 2000, the HMO became a wholly owned subsidiary of UnitedHealthcare, Inc., (UHc) pursuant to a transfer of 100% of the HMO’s outstanding shares to UHc by UHS. UHc is a Delaware corporation and wholly owned subsidiary of UHS designed to be the holding company for all of the HMOs that are part of the UnitedHealth Group. UnitedHealth Group Incorporated (United) is the ultimate controlling person in the insurance holding company system. United changed its name from United HealthCare Corporation effective March 6, 2000. On October 9, 1999, the HMO's board amended the Articles of Incorporation to change the corporate name to its current name, UnitedHealthcare of Wisconsin, Inc., effective December 31, 1999.

The HMO provides primary health care through physicians who either contract directly with the HMO, or contract with an independent practice association (IPA) or clinic that has a contractual relationship with the HMO. The HMO contracts with over 5,141 physicians (primary and specialist) and with 21 IPAs or clinic groups. The HMO's enrollees must choose to receive primary care from one of the IPAs, clinics, or individual physicians.

Under the Participating Physician Agreement, the physician agrees to provide health services in accordance with the benefit plans offered by the HMO. Pursuant to that agreement, the physician agrees to provide health services to all members as the physician's patient load permits, and to accept members as new patients on the same basis that the physician is accepting non-members as new patients, in accordance with local, state and federal laws. In addition, if the physician is a primary care physician, the physician agrees to provide or arrange for the provision of advice and assistance to members in emergency situations 24 hours/day, 7 days/week.

Pursuant to the Participating Physician Agreement, physicians are compensated in accordance with approved fee schedules. The only exception is the Downtown Health Center, which provides medical services to Medicaid enrollees only and receives compensation based on capitated rates. The agreement precludes physicians from billing members for the difference between customary charges and the amount that the physician has agreed to accept as full reimbursement under the agreement. A summary of Wisconsin's statutory hold-harmless provisions is included as an exhibit to this agreement. That summary specifically states: "A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable."

The HMO has established a bonus incentive pool from which physicians may earn an incentive bonus by meeting or exceeding set performance criteria, purportedly designed to increase enrollees' access to physicians, promote higher quality of services, and manage medical utilization and costs.

The HMO currently contracts with the following IPAs and Clinics:

Clinics
Advanced Health Care
All Saints Medical Group#
Children's Medical Group
CMG Independents
Columbia/St. Mary's Medical Group
Commonwealth Medical Group
Downtown Health Center*
Fine-Lando Clinic
Fort Health Care Management Services
Gundersen Health Care
Harwood Medical Associates
Kenosha Medical Group
Medical Associates Health Centers
Medical College of Wisconsin
Ministry Health Care
University of Wisconsin Medical Center
West Bend Clinic
Wilkinson Medical Clinic

IPAs
Independent Physicians Network
Physicians Health Network – Sheboygan
Waukesha/Elmbrook Health Care, S.C.

* Medicaid enrollees only
\# Commercial enrollees only

The contracts include hold-harmless provisions for the protection of policyholders. However, the hold-harmless provisions do not affect the enrollees' liability to pay deductibles, co-payments, or charges for noncovered services.

The HMO contracts with 26 hospitals to provide inpatient services. Hospitals are reimbursed on a negotiated per diem, per case, per visit and discounted fee-for-service basis. The contracts include hold-harmless provisions for the protection of policyholders.

The following is a listing of hospitals in which the HMO holds direct contracts:

Children's Hospital of Wisconsin	St. Francis Hospital
Columbia Center LLC	St. Joseph's Hospital – Milwaukee
Columbia Hospital	St. Joseph's West Bend Hospital
Community Memorial Hospital	St. Luke's Hospital Racine
Elmbrook Memorial Hospital	St. Mary's Hospital – Madison
Fort Atkinson Memorial Hospital	St. Mary's Hospital – Milwaukee
Froedtert Memorial Hospital	St. Mary's Hospital – Ozaukee
Kenosha Hospital & Medical Center	St. Mary's Hospital – Racine
Lakeview Neuro Rehabilitation Center	St. Michael's Hospital
New London Family Medical Center	St. Nicholas Hospital
Oconomowoc Memorial Hospital	Sheboygan Memorial Medical Center
Orthopedic Hospital	Waukesha Memorial Hospital
Sacred Heart Rehabilitation Hospital	Wisconsin heart Hospital

According to its business plan at December 31, 2003, the HMO's service area was comprised of the following counties: Dodge, Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Sheboygan, Walworth, Washington, and Waukesha.

The HMO offers comprehensive health care coverage through its commercial HMO product, which may be changed by riders to include deductibles and co-payments. The following basic health care coverages are provided:

- Ambulance Services
- Chiropractic Services
- Dental/Anesthesia Services – Hospital or Ambulatory Surgery
- Dental Services – Accident only
- Diabetes Treatment
- Emergency Services
- Eye Examination
- Home Health Care
- Hospice
- Hospital – Inpatient Services
- Kidney Disease Treatment
- Maternity Services
- Mental Health and Substance Abuse Services – Outpatient, Inpatient and Transitional Care
- Outpatient Surgery, Diagnostic Therapeutic Services
- Physician's Office Services
- Professional Fees for Surgical and Medical Services
- Prosthetic Devices & Durable Medical Equipment
- Rehabilitation Services – Outpatient Therapy
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
- Temporomandibular Joint Disorders
- Transplantation Services
- Urgent Care Services

In addition, outpatient prescription drug coverage can be added to many of the policies through a rider.

Inpatient mental health and AODA coverage is limited to $7,000, outpatient mental health and AODA coverage is limited to $2,000 per year, emergency services have a co-payment range from $0 to $250 which is waived upon admission into an inpatient facility, and skilled nursing care is limited to 30 days. Plan coverage is contingent on non-emergency services being provided by participating physicians and hospitals or on the referral of participating physicians.

The HMO also offers two point-of-service (POS) products called Select Plus and Choice Plus. These products provide comprehensive benefits similar to the commercial HMO product; however, policyholders are not restricted to participating providers, and are not required to obtain primary care physician referrals for specialist or out-of-network care. These products are jointly offered through an affiliate, United HealthCare Insurance Company (UHI). As described in the certificates of coverage, the HMO retains the risk for in-network care, out-of network emergency and urgent care, and out-of-network care pursuant to participating physician referral. UHI is responsible for the risk for all out-of-network self-referral claims with the exception of emergency or urgent care services. In return for this coverage, UHI receives 8% of premiums received pursuant to a Premium Allocation Agreement dated January 1, 1998. In addition, the HMO has an aggregate excess of loss reinsurance agreement with UHI effective August 1, 1990, to cover in-network POS claims in excess of a fixed percentage of in-network premiums. The Premium Allocation Agreement and the aggregate excess of loss reinsurance agreement are discussed in detail in the “Affiliated Companies” section of this report. The benefits for these products may be changed by riders to include various levels of deductibles, co-payments, and out-of-pocket ceilings.

The HMO entered into a Medicare Advantage (f/k/a Medicare+Choice) contract with the Health Care Financing Administration (HCFA) in 1995, now called the Centers for Medicare and Medicaid Services (CMS). The Medicare Advantage program was established pursuant to the Balanced Budget Act of 1997, and replaced the existing Medicare risk program. Beneficiaries under the Medicare Advantage contract must use the HMO’s network of providers, with the exception of medically necessary emergency health services and health services provided in an urgent care center outside of the service area. Under the contract, the HMO agrees to provide enrollees with Medicare Part A and Part B benefits, as well as supplemental benefits as established in the HMO's adjusted community rate proposal as approved by CMS. CMS reimburses the HMO in accordance with a capitated rate, which is adjusted for demographic risk factors such as a beneficiary's age, disability status, sex, institutional status, and other factors as CMS deems appropriate. The current contract period runs from January 1, 2004, to December31, 2004.

The HMO derives approximately 19% of its revenues from Wisconsin's Medicaid/Badgercare Program. The HMO contracts directly with the Wisconsin Department of Health and Family Services (DHFS), to provide specified health care benefits to eligible Medicaid Assistance/Badgercare recipients. In exchange for these services, UHCW is paid a monthly capitation rate, which is designed to be less than the cost of providing the same services covered under the contract to a comparable Medicaid population on a fee-for-service basis. The current contract with DHFS will expire on December 31, 2004

In addition to the products mentioned above, the HMO administers managed care benefits for self-insured employers through administrative service only (ASO) contracts. Although the benefits offered are determined on a group-by-group basis, they are substantially similar to the HMO products. The HMO is not at risk for the provision of these services.

The HMO currently markets its commercial HMO product to groups only. The HMO uses outside agencies and pays commissions ranging from 1% to 13% on new and renewal business with the exception of small market groups. For small market groups, agents are paid according to a predetermined per member per month rate, ranging from $10 to $29 depending on the number of subscribers.

For large groups, the HMO looks at a combination of actual claims experience and medical trend to determine premium rates. For other groups, the HMO uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the age, sex, occupation, and coverage characteristics for new groups. Experience is reviewed for renewal groups and, based on the review; a recommendation is made regarding adjusting the rate or canceling the group. The base rate is adjusted quarterly for inflation and other trending factors. Medicaid/Badgercare and Medicare rates are negotiated between the HMO and the sponsoring state agency (DHFS for Medicaid/Badgercare), or sponsoring federal agency (CMS for Medicare).

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of four members and one vacant position (see "Subsequent Events" section of this report). All directors are elected annually to serve a one-year term. Officers are appointed by the board of directors. Members of UnitedHealthcare of Wisconsin's board of directors may also be members of other boards of directors in the holding HMO group. The board members currently receive no compensation for serving on the board.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Eric E. Christianson, M.D. Pewaukee, WI	Senior Medical Director UnitedHealthcare of Wisconsin, Inc.	2005
Jay R. Fulkerson Appleton, WI	President and CEO UnitedHealthcare of Wisconsin, Inc.	2005
David S. Wichmann Burnsville, MN	Vice President and Asst. Treasurer UnitedHealthcare of Wisconsin, Inc.	2005
Robert J. Sheehy Edina, MN	Executive Vice President UnitedHealthcare of Wisconsin, Inc.	2005

Officers of the Company

The officers appointed by the board of directors and serving at the time of this examination are as follows:

Name	Office	2003 Salary
Jay R. Fulkerson	President, CEO	**
George L. Mikan, III	Vice President, Ass't. Treasurer	*
Robert J. Sheehy	Executive Vice President	*
Robert W. Oberrender	Treasurer	*
Michael J. McDonnell	Secretary	*
Timothy G. Caron	Asst. Secretary	*
David J. Lubben	Asst. Secretary	*
Mary L. Stanislav	Asst. Secretary	*
Glenn J. Reinhardt	COO	*
Eric E. Christianson, M.D.	Senior Medical Director	*

* These individuals are compensated by United HealthCare Services, Inc.
** This individual was not affiliated with UnitedHealth Group, Incorporated during 2003.

Committees of the Board

The HMO's bylaws allow for the formation of certain committees by the board of directors. The committees at the time of the examination that are specific to the HMO are listed below:

Quality Improvement Committee	Medical Advisory Board
Vacant, Chair[1]	Eric Christianson, M.D., Chair
Eric Christianson, M.D., Co-Chair	Andrew Martorana, M.D.
Glen Reinhardt	Thomas Gvora, M.D.
Kurt Janavitz	Michael Schatzman, M.D.
Dustin Hinton	John Waeltz, M.D.
Stacy Jo Johnson	Russel Yale, M.D.
Teri Frederickson	James Enos
John Tenaglia	Sara O'Neill
Christopher Abbott	Heather Scalia
Scott Dent	
Sara O'Neill	

The HMO has no employees. Necessary staff is provided through a management agreement with United HealthCare Services, Inc. (UHS). Under the agreement, effective January 1, 2001, UHS agrees to negotiate employer, provider, subscriber, and other contracts; advises the board; maintains accounting and financial records; recruits marketing, utilization review, and claims processing personnel; provides or contracts for claims processing, and MIS. UHS receives a monthly management fee, calculated as 8.5% of gross revenues, as compensation for services rendered. The term of the agreement is continuous. Either party may terminate the agreement upon 180 days' written notice to the other party.

[1] This position was occupied by William Felsing who resigned as President and CEO during examination fieldwork. The board is currently in the process of finding a replacement for Mr. Felsing on this committee.

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

	Amount Required
1. Minimum capital or permanent surplus	Either: $750,000, if organized on or after July 1, 1989 or $200,000, if organized prior to July 1, 1989
2. Compulsory surplus	The greater of $750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3. Security surplus	The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each $33 million of additional premiums earned in excess of $10 million or 110% of compulsory surplus
4. Operating funds	Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;

2. One-third of 1% of premium written in this state in the preceding calendar year.

The company has satisfied this requirement for 2003 with a deposit of $5,900,000 with the State Treasurer.

Insolvency Protection for Policyholders

Section Ins 9.04 (6), Wis. Adm. Code, requires HMOs to either maintain compulsory surplus at the level required by s. Ins 51.80, Wis. Adm. Code, or provide for the following in the event of the company's insolvency:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The company has met this requirement through its provider and reinsurance contracts.

IV. AFFILIATED COMPANIES

The HMO is a member of a holding company system. Its ultimate parent is UnitedHealth Group Incorporated. Below is a brief description of the significant affiliates with which the HMO has transactions. An abbreviated organizational chart, as of December 31, 2003, which depicts the relationships among the significant affiliates in the holding company system follows the descriptions.

UnitedHealth Group Incorporated

UnitedHealth Group Incorporated (United), the ultimate controlling person in the insurance holding company system, is a diversified health and well-being company serving approximately 52 million members throughout the United States. Through its affiliated companies, UnitedHealth Group offers a broad spectrum of health care products and services. As of December 31, 2003, the company's consolidated audited financial statement reported assets of $17.6 billion, liabilities of $12.5 billion, and shareholder's equity of $5.1 billion. Operations for 2003 produced net income of $1.8 billion.

The HMO currently has the following affiliated agreements with United:

- Revolving Credit Agreement: Effective 12/1/1999, the HMO entered into a Revolving Credit Agreement with United. Under this agreement, United will provide the HMO with a short-term borrowing facility. The HMO may borrow funds upon demand from United, up to a maximum of $10 million, at an interest rate equal to the LIBOR rate plus 50 basis points.

- Tax Sharing Agreement: Effective 8/1/1991, the HMO entered into a Tax Sharing Agreement with United. Under this agreement, United will file a consolidated tax return for member companies; member companies in turn agree to make quarterly payments to United, in an amount equal to the full separate federal, state and local income tax liability attributable to the net taxable income of each member that would have been paid if such member had filed separate federal, state and local tax returns.

United HealthCare Services, Inc.

United HealthCare Services, Inc., (UHS) a wholly owned subsidiary of UnitedHealth Group, provides administrative and other services to various member companies in the holding company group. As of December 31, 2003, the company's consolidated audited financial statement reported assets of $13.4 billion, liabilities of $8.9 billion, and shareholder's equity of $4.5 billion. Operations for 2003 produced net income of $1.7 billion.

The HMO currently has the following affiliated agreements with UHS:

- Management Agreement: The HMO has a management agreement with UHS, whereby UHS will provide administrative and management services to the company, until terminated upon written agreement of both parties. [As mentioned in the "Management & Control" section of this report, the HMO has no employees.] Under the management agreement effective in 2000, UHS retained the employees and the compensation expense passed directly to the HMO via the management agreement. This agreement was restructured in 2001; consequently, UHS now retains the compensation expense for a higher management fee. Under the current management agreement, the HMO pays UHS a monthly management fee, calculated as 8.5% of gross revenues (member premium and government program revenue) for that month.

- Pharmacy Benefit Services Agreement: The HMO has an agreement with UHS to provide administrative services related to pharmacy management and claims processing for its enrollees. [UHS, in turn, contracted these services out in 2000 to Merck-Medco (Merck), respectively.] The current agreement commenced on October 1, 2000, and is effective until December 31, 2005, unless terminated earlier upon written agreement of both parties.

- Transplant Services Agreement: The HMO has an agreement with United Resource Networks, a division of UHS, to provide access to a network of transplant providers for the HMO's enrollees. The agreement commenced on January 1, 1994, and may be terminated at any time upon mutual agreement of the parties.

- OPTUM Care24 Services Agreement: The HMO has an agreement with OPTUM, a division of UHS, to provide a 24-hour call-in service, called Care24, to its enrollees. Services provided under Care24 consist of education, information, problem assessment, assistance, crisis management and referral for covered person's problems relating to marital/family relations, dependent/adult care, financial/legal issues, chemical/alcohol dependency, illnesses, work-related problems, general health information, identification of specific health-related concerns, and provision of educational information regarding those concerns.

- OPTUM Health Pregnancy Services Agreement: The HMO has an agreement with OPTUM, a division of UHS, to provide health pregnancy services. Services provided under this agreement consist of telephone screening of covered pregnant members, and calls to members postpartum. The agreement commenced on January 1, 1999, and will automatically renew for additional 1-year terms unless either party provides 30 days prior notice of its intent not to renew the agreement.

- Chiropractic Service Agreement: The HMO has an agreement with ACN Group, Inc., a division of UHS, to provide chiropractic and physical therapy services for its enrollees. The agreement commenced on July 1, 2002, and will automatically renew for additional 1-year terms unless either party provides 180 days prior notice for its intent not to renew the agreement.

- Mental Health/Substance Abuse Services Agreement: The HMO has an agreement with United Behavioral Health for the provisions of certain mental health and substance abuse treatment services for its members and employees. The agreement commenced on January 1, 1998, and will automatically renew for additional 1-year terms unless either party provides 90 days prior notice of its intent not to renew the agreement.

- Vision Care Services Agreement: The HMO has an agreement with Coordinated Vision Care, Inc., a division of UHS, to provide vision care services to its enrollees. The agreement commenced on September 21, 1999, and will automatically renew for additional 1-year terms unless either party provides 120 days prior notice of its intent not to renew the agreement.

United HealthCare Insurance Company, Inc.

United HealthCare Insurance Company, Inc., (UHI) is a wholly owned subsidiary of Unimerica, Inc. (which is a wholly owned subsidiary of UHS). The company is licensed to sell life and accident and health insurance in most states, and primarily issues group accident and health insurance contracts to employers and associations. As of December 31, 2003, the company's audited financial statement reported assets of $5.9 billion, liabilities of $4.4 billion, and capital and surplus of $1.5 billion. Operations for 2003 produced net income of $1.2 billion.

The HMO currently has the following agreements with UHI:

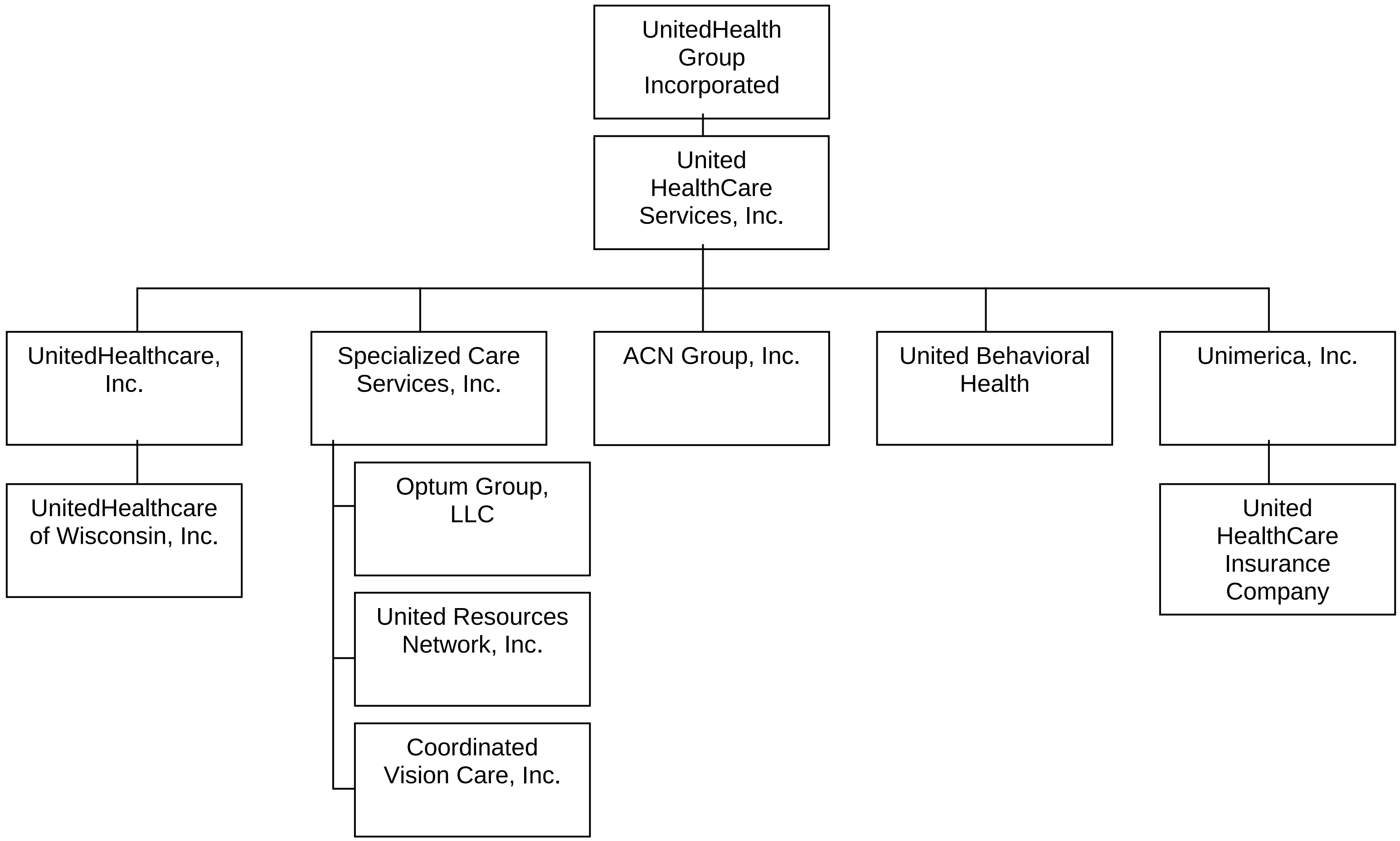
- Premium Allocation Agreement (POS Product): The HMO has a premium allocation agreement with UHI with respect to the point-of-service (POS) product that is offered jointly by the two insurers. The agreement commenced on January 1, 1998, and will continually renew each January 1st, unless terminated by either party upon 180 days prior written notice to the other party. Under the agreement, UHI receives a percentage of the POS premiums, in return for providing out-of-network coverage for this product. Under the current agreement, UHI receives 8% of the premium for its obligations under the contract.

- Reinsurance Agreement (POS Product): The HMO has an aggregate excess of loss agreement with UHI that covers in-network POS claims. The agreement commenced on August 1, 1990, and will remain in force unless terminated by mutual agreement of the parties. Under terms of this agreement, UHI will reimburse the HMO for aggregate claims in excess of 90% of gross earned premiums. Under the current agreement, UHI receives 1% of gross earned premiums covered under the contract. [Further details concerning this agreement can be found in the "Reinsurance" section of this report.]

- Reinsurance Agreement: The HMO has a specific excess of loss agreement with UHI that covers all eligible inpatient services for non-1991, and will continue in full force until terminated by either party upon 90 days' prior written notice. Under the current agreement, UHI receives a per member per month fee according to the following schedule. [Further details concerning this agreement can be found in the "Reinsurance" section of this report.]

Holding Company Chart

As of December 31, 2003



V. REINSURANCE AND CORPORATE INSURANCE

The company has reinsurance coverage under the contract outlined below:

1.	Reinsurer:	United HealthCare Insurance Company, Inc.
	Type:	Specific Excess of Loss Reinsurance
	Effective date:	July 1, 1991
	Lines Covered:	All Lines
	Retention:	Commercial Members - $150,000/member/year; 20% coinsurance Medicaid Members - $100,000/member/year; 10% coinsurance Medicare Members - $100,000/member/year; 10% coinsurance
	Coverage:	Maximum annual coverage of $2,000,000 for eligible inpatientservices, after deductible and coinsurance
	Premium:	$0.53 per commercial member per month $0.37 per Medicaid member per month $0.63 per Medicare member per month
	Termination:	The contract took effect on July 1, 1991, and shall continue in full force until terminated by either party giving at least 90 days' written notice prior to the anniversary of the effective date.

The reinsurance policy has an endorsement containing the following insolvency provisions:

1. The reinsurer will continue the Plan benefits as defined in the Membership Service Agreements, for Commercial and Medicaid members who are receiving non-custodial care while confined in an inpatient facility on the date of the insolvency, until their discharge.

   In addition, the reinsurer will continue the Plan benefits as defined in the Member Service Agreements, for Medicare members who are receiving non-custodial care while confined in an inpatient facility, skilled nursing facility or rehabilitation facility on the date of the insolvency, until their discharge.

2. The reinsurer will continue the Plan benefits as defined in the Membership Service Agreement, for any member until the end of the contract period for which premium was paid to the Plan by or on behalf of the member.

3. Each Member for himself and covered dependents shall have the right to convert within thirty days of the date of insolvency, without evidence of insurability, to coverage then being offered by the reinsurer to other insured's eligible for conversion under its group insurance policies with the same benefits and at the same rates as offered to such other insured's.

2. Reinsurer: United HealthCare Insurance Company, Inc.

Type:	Aggregate Excess of Loss Reinsurance
Effective date:	August 1, 1990
Lines Covered:	Point of Service
Retention:	90% of gross earned premium for the POS product
Coverage:	The reinsurer is liable for the amount by which the HMO's ultimate net loss exceeds its retention.
Premium:	1% of gross earned premium
Termination:	The contract shall automatically be renewed each January 1st, unless mutually terminated by the parties to the contract

In addition, the company is provided with corporate insurance coverage under the contracts listed below:

Type of Coverage	Policy Limits
Professional Liability	$25,000,000
General Liability	1,000,000/Occurrence; 3,000,000/Aggregate
Directors' and Officers' Liability	25,000,000
Automobile Liability	1,000,000
Crime	25,000,000
Property	25,000,000/Location
Umbrella	25,000,000

The above coverage's were obtained through various insurers which are licensed in Wisconsin, or on the Commissioner's current list of approved surplus lines insurers.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported in the December 31, 2003, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the company for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

UnitedHealthcare of Wisconsin, Inc.
Assets
As of December 31, 2003

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$121,808,176	$	$121,808,176
Real Estate:			
Properties occupied by the company	9,922,083		9,922,083
Cash, cash equivalents and short-term investments	65,880,275		65,880,275
Receivable for securities	37,676		37,676
Investment income due and accrued	1,609,354		1,609,354
Uncollected premiums and agents' balances in the course of collection	1,877,015	589,865	1,287,150
Amounts receivable relating to uninsured plans	285,013		285,013
Net deferred tax asset	4,490,574	125,000	4,365,574
Electronic data processing equipment and software	758	758	0
Receivables from parent, subsidiaries and affiliates	540,846	540,846	0
Health care and other amounts receivable	2,840,343	846,962	1,993,381
Prepaids	175,794	175,794	0
Intangible assets and goodwill (net)	472,856	472,856	0
Total assets	$209,940,763	$2,752,081	$207,188,682

UnitedHealthcare of Wisconsin, Inc.
Liabilities and Net Worth
As of December 31, 2003

Claims unpaid		$ 71,509,638
Accrued medical incentive pool and bonus payments		1,838,193
Aggregate health policy reserves		150,207
Aggregate health claim reserves		1,336,806
Premiums received in advance		20,613,558
General expenses due or accrued		4,377,380
Current federal and foreign income tax payable and interest thereon		5,964,935
Remittance and items not allocated		208,133
Aggregate write-ins for other liabilities [including $(1) current]		1,462,656
Total liabilities		107,461,506
Common capital stock	$ 1,000	
Gross paid in and contributed surplus	31,627,240	
Unassigned funds (surplus)	68,098,936	
Total capital and surplus		99,727,176
Total liabilities, capital and surplus		$207,188,682

UnitedHealthcare of Wisconsin, Inc.
Statement of Revenue and Expenses
For the Year 2003

Net premium income		$687,000,159
Medical and Hospital:		
Hospital/medical benefits	$464,298,213	
Other professional services	2,953,296	
Prescription drugs	74,062,654	
Aggregate write-ins for other medical and hospital	(140,797)	
Incentive pool and withhold adjustments	4,341,732	
Subtotal	545,515,098	
Less		
Net reinsurance recoveries	2,387,238	
Total medical and hospital	543,127,860	
Claims adjustment expenses	18,211,320	
General administrative expenses	70,487,698	
Increase in reserves for life and accident and health contracts	140,969	
Total underwriting deductions		631,967,847
Net underwriting gain or (loss)		55,032,312
Net investment income earned	6,556,221	
Net realized capital gains or (losses)	112,835	
Net investment gains or (losses)		6,669,056
Aggregate write-ins for other income or expenses		12,489
Net income or (loss) before federal income taxes		61,713,857
Federal and foreign income taxes incurred		21,287,000
Net income (loss)		$ 40,426,857

UnitedHealthcare of Wisconsin, Inc.
Capital and Surplus Account
As of December 31, 2003

Capital and surplus prior reporting year		$56,193,239
Net income or (loss)	$40,426,857	
Change in net deferred income tax	773,907	
Change in nonadmitted assets	2,333,173	
Net change in capital and surplus		43,533,937
Capital and surplus end of reporting year		$99,727,176

UnitedHealthcare of Wisconsin, Inc.
Statement of Cash Flows
As of December 31, 2003

Premiums collected net of reinsurance		$684,686,263
Net investment income		7,470,424
Miscellaneous income		1,750,965
Total		693,907,652
Less:		
Benefit and loss related payments	$570,513,781	
Commissions, expenses paid and aggregate write-ins for deductions	69,157,743	
Federal and foreign income taxes paid (recovered) $0 net tax on capital gains (losses)	17,966,838	
Total		657,638,362
Net cash from operations		36,269,290
Proceeds From Investments Sold, Matured or Repaid:		
Bonds	19,265,411	
Cost of Investments Acquired - Long-Term Only:		
Bonds	12,052,124	
Net cash from investments		7,213,287
Cash Provided/Applied:		
Other cash provided (applied)		(1,011,167)
Net change in cash and short-term investments		42,471,410
Beginning of year (cash and short-term investments)		23,408,865
End of year (cash and short-term investments)		$ 65,880,275

Growth of UnitedHealthcare of Wisconsin, Inc.

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2003	$207,188,682	$107,461,506	$99,727,176	$687,000,159	$543,127,860	$40,426,857
2002	173,506,443	117,417,677	56,193,239	714,473,701	612,197,567	14,043,091
2001	165,773,632	113,884,292	51,889,340	667,046,964	575,323,546	20,199,379
2000	158,433,951	110,616,024	47,817,927	501,217,370	424,243,304	18,126,901

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2003	5.9%	79.1%	10.3%	-17.9%
2002	2.0	85.7	9.7	-2.7%
2001	3.0	86.2	10.0	12.2%
2000	3.6	84.6	11.1	21.2%

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2003	227,703	383.19	4.8
2002	277,325	331.47	3.7
2001	285,055	422.79	4.7
2000	254,017	261.17	5.1

Per Member Per Month Information

	2003	2002	Percentage Change
Premiums:			
Commercial	$263.63	$229.77	14.7%
Medicare	528.56	573.62	-7.9
Medicaid	150.00	143.62	4.4
Expenses:			
Hospital/medical benefits	$171.37	$162.75	5.3
Other professional services	1.09	-4.11	-126.5
Prescription drugs	27.34	24.25	12.7
Other medical and hospital	-0.05	-0.15	-66.7
Incentive pool and withhold adjustments	1.60	0.92	73.9
Less: Net reinsurance recoveries	0.88	0.73	20.5
Total medical and hospital	200.47	182.93	9.6
Claims adjustment expenses	6.72	6.13	9.6
General administrative expenses	26.02	20.75	25.4
Increase in reserves for accident and health contracts	0.05	0.00	N/A
Total underwriting deductions	$233.26	$209.82	11.2%

In 2003, UHCW reported its largest net income for the three-year period despite a 17.9% decrease in membership. The increased net income is primarily due to increased premium rates and decreased medical expenses. The HMO's medical expense ratio decreased to 79.1% in 2003 from 85.7% in 2002. The decrease in membership is a result of a decline in medicaid and commercial business. The HMO had a slight increase in Medicare business during 2003. Medicaid business decreased when UHCW exited Ozaukee and Washington counties in late 2002 and Kenosha County in January 2003. Commercial enrollment decreased primarily from groups migrating to self-funded products from fully insured products, and groups moving to United Healthcare Insurance Company products.

Reconciliation of Capital and Surplus per Examination

The examination made no adjustments to net worth as reported by UnitedHealthcare of Wisconsin, Inc. at December 31, 2003. In addition, there were no examination reclassifications.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were two specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the company are as follows:

1. Service Area—It is recommended that the company discontinue reporting the counties of Dane, Rock and Green in its service area on the Annual Statement.

   Action—Compliance.

2. Short-Term Investments—It is recommended that the company exclude investments in excess of statutory limitations from its compulsory and security surplus calculation as required by s. 620.21, Wis. Stat.

   Action—Noncompliance, see comments in the summary of current examination results.

Summary of Current Examination Results

Holding Company

The examination noted that the HMO did not disclose a contract with an affiliate, Coordinated Vision Care, Inc., in its Insurance Holding Company System Annual Registration Statement (Form B) filing. Section Ins 40.03 (3), Wis. Adm. Code, states “all management agreements, exclusive agent agreements, service contracts and all cost-sharing agreements” shall be reported in the annual Form B filing. It is recommended that the HMO complete its annual Form B filing in accordance with s. Ins 40.03 (3), Wis. Adm. Code.

Short-Term Investments

The examination noted that the HMO reported investments in the following: $23 million in JP Morgan Funds Money Market, $25.4 million in Nations Cash Reserve Money Market Fund, and $26 million in UHC HealthCare Liquidity Pool. The short-term investment pool was established by United HealthCare Services, Inc., (UHS) through an agreement with Banc One (the agreement was formerly with Travelers Asset Management International Corporation). UHCW became a participant in the pool in 1997. The terms of this agreement are summarized as follows:

- Pool investments are managed by Banc One. Investments will generally have maturities of 397 days or less and shall have an SVO rating of 1 or 2 or an equivalent rating.
- UHS together with the pool participants will be the beneficial owners of all assets in the pool. The pool assets will be held under a custodial arrangement with a third party and shall not be commingled with the assets of Banc One or any other person. Each pool participant will own an undivided interest in the underlying pool assets. Each pool participant on a pro rata basis shall own all investments purchased by the pool.
- The proportional share of each pool participant is calculated daily based on the market value of the underlying assets. Interest earned is credited at least monthly. UHS may withdraw all of any portion of the assets at any time.
- Any pool participant or, in the event of liquidation of a pool participant, its trustee or receiver may make withdrawals on demand without penalty. The distribution may be made in cash and/or in kind distributions.

Section 620.23 (2) (b), Wis. Stat., limits an insurer’s investment in all securities of a single issuer and its affiliates to 10% of assets. In addition, s. 620.22 (9), Wis. Stat., permits an additional 5% in investments not otherwise covered in the statutes. Pursuant to s. 620.21, Wis. Stat., the amount of the investment exceeding these limitations cannot be counted toward satisfying the compulsory and security surplus requirement. The following reflects investments that exceed the limitation:

10% of Admitted Assets		$20,718,862
Fund Name	**Carrying Value**	**Excess Investment**
JP Morgan Funds MMKT	$23,028,696	$ 2,309,834
Nations Cash Reserve MMF	25,405,949	4,687,087
UHC HealthCare Liquidity Pool	25,998,339	5,279,447
Total Excess Investment over 10%		12,276,368
Less:		
Additional 5% of Assets Allowed		10,359,431
Excess		$ 1,916,937

The $1,916,937 difference has been adjusted in the compulsory surplus calculation following this section. It is again recommended that the HMO exclude investments in excess of statutory limitations from its compulsory and security surplus calculation as required by s. 620.21, Wis. Stat.

Premium

The examination review of UHCW's premium processing and application of premium payments noted that payments for "small" groups are applied on the "first-in first-out" (FIFO) method. Under this method it is difficult for the HMO to adequately keep track of which months and which member's employers are actually paying for. The current design does not lend itself to adequate tracking of older balances and group enrollees. It is recommended that the HMO make necessary changes so that the aging of premium receivables will more accurately reflect any balances over 90 days past due and report them in accordance with the NAIC Accounting Practices and Procedures Manual.

Annual Statement

The review of the annual statement disclosed the errors listed below:

- Schedule A, Part 1—Real Estate Owned understated the Fair Value Less Encumbrances, and did not disclose Gross Income Earned Less Interest Incurred on Encumbrances, and Taxes Repairs and Expenses Incurred on Real Estate.

- Schedule D, Part 1—Long-term Investments Owned disclosed maturity dates for various securities at the estimated retirement date of the bond versus the maturity date "stated" on the security.

- Schedule DA, Part 1—Short-term Investments Owned did not disclose the proper NAIC Designation for various short-term investments.
- Asset Page showed an amount for "Receivable for securities" which based on the examination was deemed to be additional "Investment income due and accrued." Due to immateriality of the amount no reclassification was made.

It is recommended that the company properly complete the annual statement in accordance with the NAIC Annual Statement Instructions – Health regarding the issues noted above.

Disaster Recovery

The examination noted that the HMO had disaster recovery plans for its data centers, but there were no business continuity plans for the group's function units. The HMO is in the process of completing the plans for the function units done at a subsidiary and functional level to satisfy HIPAA requirements mandated for April 2005. It is suggested that the company create a disaster recovery plan for its functional units and that the plan be reviewed, updated, and tested annually.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The company's calculation as of December 31, 2003, as modified for examination adjustments is as follows:

Assets	$207,188,682	
Less:		
Special deposit	5,848,879	
Liabilities	107,461,506	
Investment in excess of statutory limitations	1,916,937	
Total		$91,961,360
Net premium earned	687,000,159	
Compulsory factor	3%	
Compulsory surplus		20,610,005
Compulsory Excess		$71,351,355

VIII. CONCLUSION

UnitedHealthcare of Wisconsin, Inc., is a for-profit network model HMO serving ten counties in southeastern Wisconsin. The HMO commenced business in June 1986 and subsequently underwent a number of mergers, acquisitions, and name changes. The HMO became a wholly owned subsidiary of UnitedHealthcare, Inc., on June 30, 2000, and acquired its current name, UnitedHealthcare of Wisconsin, Inc., (formerly PrimeCare Health Plan, Inc.) pursuant to an amendment to the Articles of Incorporation effective December 31, 1999.

The HMO had positive operating results over the examination period with 2003 being the most profitable. UHCW reported net income of $40.4 million in 2003 despite a 17.9% decrease in enrollment. Enrollment decreases were a result of reduced Medicaid enrollment from exiting two counties in late 2002 and one in early 2003, and commercial groups going from fully insured products to self-funded products and to United HealthCare Insurance Company products.

The HMO complied with one prior recommendation and one recommendation resulted in noncompliance. The examination resulted in four recommendations and one suggestion regarding the holding company registration filing, invested assets, short-term investments, premium accounting, various annual statement errors, and disaster recovery.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 27 - Holding Company—It is recommended that the HMO complete its annual Form B filing in accordance with s. Ins 40.03 (3), Wis. Adm. Code.

2. Page 28 - Short-Term Investments—It is again recommended that the HMO exclude investments in excess of statutory limitations from its compulsory and security surplus calculation as required by s. 620.21, Wis. Stat.

3. Page 28 - Premium—It is recommended that the HMO make necessary changes so that the aging of premium receivables will more accurately reflect any balances over 90 days past due and report them in accordance with the NAIC Accounting Practices and Procedures Manual.

4. Page 29 - Annual Statement—It is recommended that the company properly complete the annual statement in accordance with the NAIC Annual Statement Instructions – Health regarding the issues noted above.

5. Page 29 - Disaster Recovery—It is suggested that the company create a disaster recovery plan for its functional units and that the plan be reviewed, updated, and tested annually.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the company is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination:

Name	Title
Rebecca Easland	Insurance Financial Examiner
Glen Navis	Insurance Financial Examiner
Randy Milquet	Examiner - Advanced

Respectfully submitted,

Amy J. Wolff
Examiner-in-Charge

XI. SUBSEQUENT EVENT

On March 31, 2004, UnitedHealthcare of Wisconsin, Inc., acquired Touchpoint Health Plan's HMO and POS products under a 100% quota-share reinsurance agreement. UHCW expects that 100% of Touchpoint's business will be transferred by December 2005 by renewing Touchpoint customers' contracts as they expire. As a condition of the acquisition, the HMO will contract with current Touchpoint providers for seven years. As a result of this transaction, the HMO's service area is now comprised of the following counties:

Brown	Manitowoc	Racine
Calumet	Marinette	Shawano
Dodge	Marquette	Sheboygan
Door	Menominee	Walworth
Fond du Lac	Milwaukee	Washington
Green Lake	Oconto	Waukesha
Jefferson	Outagamie	Waupaca
Kenosha	Ozaukee	Waushara
Kewaunee	Portage	Winnebago

On October 13, 2004, the HMO's President and CEO, William Felsing, resigned from UHCW. Jay Fulkerson, President and CEO – North Market, will replace Mr. Felsing as President and CEO for all of UHCW. The board of UHCW is currently in the process of filing Mr. Felsing's positions on various committees.